NARFE'S POSITION ON COMPREHENSIVE HEALTH CARE REFORM AND A SUMMARY OF PROVISIONS RELEVANT TO FEDERAL WORKERS AND ANNUITANTS

NARFE as yet has taken no position on the overall health care reform legislation receiving serious consideration in the House and the Senate. That is because the status of the leading bills is extremely fluid and is subject to change, particularly after lawmakers talk to their constituents about this issue during the August recess.

The NARFE Legislative Program for the 111th Congress (2009-2010) states that "NARFE supports access to comprehensive health care for all Americans." However, the legislative program is silent on how universal access should be achieved. This position has been reaffirmed by NARFE officers and members who attended the last several national biennial conventions. The legislative program can be found online at http://www.narfe.org/pdf/1-2.pdf.

August 2009 Grass-Roots Advocacy Month Talking Points

During the August Grass-Roots Advocacy Month, NARFE members should discuss the following NARFE health care reform goals and concerns (each of these points is discussed in more detail in the pages which follow this section):

- **Premium Conversion:** NARFE supports adding a proposal to health care reform legislation which would permit federal civilian annuitants as well as active duty military personnel and retirees to join their active duty civilian colleagues in paying their share of employer-sponsored health insurance with pretax compensation. Should Congress consider taxing employees and retirees for part of the value of their employer-provided health insurance, NARFE would reevaluate its position on premium conversion (for an explanation, read the fourth paragraph of "Taxing Health Benefits").

- **Opening the Federal Employees Health Benefits Program to Non-Federal Civilians:** Although NARFE supports access to comprehensive health care for all Americans, the Association would oppose legislation which would open the FEHBP to non-federal enrollees without calculating their premiums separately in their own insurance risk pool (see "Federal Employees Health Benefits Program").

- **Taxing Workers and Retirees for the Value of Employer-Sponsored Health Insurance:** NARFE opposes (see "Taxing Health Benefits").

- **Coverage for Temporary and Seasonal Federal Workers:** NARFE supports the concept in the "Employer Mandate" which would encourage the federal government, as an employer, to make its temporary and seasonal workers eligible for FEHBP (see "Employer Mandate").

- **Providing "Affordability Credits" to Lower Income Workers and Retirees**: Some lower income workers and retirees cannot afford to pay their share of employer-sponsored health premiums. NARFE supports a provision in the House bill which would provide such individuals with income-based credits to help them pay for private or public plan premiums offered by the Health Insurance Exchanges (see "Individual Mandate" and "Health Insurance Exchanges").

- **Coverage for dependent children up to age 26:** NARFE supports a provision in the Senate HELP Committee bill which would provide dependent coverage for children up to age 26 for all individual and group policies, including FEHBP plans (see "Federal Employees Health Benefits Program").

- **Expanding Medicaid Eligibility:** The House and Senate bills would expand eligibility in Medicaid to cover millions of low-income people who do not qualify under current law. NARFE believes individuals made eligible under this expansion should include childless adults and that Medicaid long-term care benefits be available to them. (see "Medicare and Medicaid").

- **Effect of Health Care Reform on Employers and Carriers:** NARFE is concerned that the combination of the public plan option, taxation of health insurance, and mandated benefit packages could affect the ability of employers and carriers to ensure competition and offer the same health plan choices in group health plans like the FEHBP (see "Long Term Effects of Reform").

- **Enhance "CLASS Act" Long-Term Care Insurance Program:** NARFE supports financing a more generous long-term care benefit and establishing a more robust disability evaluation and benefit claims process than proposed in the "Community Living Assistance Services and Supports" (CLASS) Act, as included in the House bill and Senate HELP Committee legislation (see "Long-Term Care").

- **End the Medicare Part D Prescription Drug Cost-Sharing "Donut Hole":** NARFE supports (see "Medicare and Medicaid").

- **Slowing the Growth of Medicare and Medicaid Provider Reimbursements:** NARFE is concerned that provider payment reform could encourage some doctors and hospitals to stop accepting Medicare and Medicaid (see "Medicare and Medicaid").

Status of Legislation

The health care reform bills receiving serious consideration are: (1) H.R. 3200, the House Tri-Committee legislation, which includes parts of the bills approved by the House Committees on

Ways and Means, Energy and Commerce, and Education and Labor; (2) the Senate Committee on Health, Education, Labor and Pensions (HELP) bill and (3) the Senate Finance Committee proposal.

On July 17, the House Ways and Means and Education and Labor Committees approved the portions of H.R. 3200 under their jurisdiction and, on July 31, the House Energy and Commerce Committee completed action on their part of the bill. The Senate HELP Committee passed their legislation on July 15 (no bill number has been assigned yet) and the Senate Finance Committee proposal is currently being negotiated by a "Gang of Six" Democratic and Republican members of the committee.

Nonpartisan analysis of the major health care reform bills is available on the Kaiser Family Foundation side-by-side bill comparison web site at: http://www.kff.org/healthreform/sidebyside.cfm . The Kaiser Foundation is not associated with Kaiser Permanente or Kaiser Industries.

The pending legislation could be changed significantly after Congress returns from the August-Labor Day recess in response to support, opposition or concerns expressed by constituents.

Federal Employees Health Benefits Program (FEHBP)

None of the pending measures under consideration would open the Federal Employees Health Benefits Program to non-federal civilians, nor would FEHBP become part of the public health care plan. At this point, there is no indication that Congress intends to open FEHBP to non-federal civilian enrollees. However, the legislation is subject to change and FEHBP, as a result, could be directly affected. It is also important to keep in mind that any comprehensive plan that changes insurance law, provider financing, taxation policy and health infrastructure, will have some ramifications on how FEHBP operates in the larger health system.

The NARFE Legislative Program opposes proposals which would "broaden participation in FEHBP, unless separate risk pools are created." Separate risk pools are necessary for assessing and adjusting the insurance risk of a new enrollment community. Without the opportunity to assess the experience of non-federal civilian enrollees in a separate FEHBP risk pool, the introduction of any new community into the FEHBP could result in unanticipated premium increases.

Like other employer-sponsored health insurance plans, pending health reform measures propose no direct changes to FEHBP until 2018. That's when FEHBP would be required under the House bill to have an "essential benefits package," offer preventive services and treatments with no additional co-payments or co-insurance, and comply with a federally-mandated coverage appeals process.

Under the House bill, the Department of Health and Human Services' (HHS) Health Benefits Advisory Committee, a group of up to 27, more than half of whom would be appointed by the President and led by the Surgeon General, would recommend what coverage should be provided in the essential benefits package and which preventive services and treatments enrollees would

be offered without paying co-payments or co-insurance. They would also establish a uniform coverage appeals process. In consultation with the Advisory Committee's recommendations, the HHS Secretary would make the final decisions on standard benefits and the appeals process.

The essential benefits package would only affect FEHBP if it includes coverage not currently offered by the federal employees program. That is unlikely to happen since most FEHBP plans offer comprehensive benefits. Like the law which authorizes the FEHBP, the House bill requires that the essential benefits package contain broad categories of benefits, including hospitalization, outpatient care, prescription drugs, rehabilitative services, mental health and substance use services, maternity and well baby care. If the essential benefits package were to exceed current FEHBP coverage, insurance carriers could raise premiums and/or increase enrollee cost sharing.

Likewise, preventive services coverage without cost sharing could result in a premium increase. Some health care policy experts argue that preventive coverage would eventually save money because such services could prevent illness or catch diseases earlier when they may be treatable. However, the nonpartisan Congressional Budget Office disputes this assumption as non-quantifiable. Whether or not preventive coverage saves or costs money, many observers believe it could improve the quality of life of patients who use such coverage and comply with lifestyle changes suggested by a physician in response to diagnosis and testing.

Since 1977, FEHBP has had a disputed claims process which ensures an independent review of disputes between participating insurance carriers and enrollees. A federally mandated process would only affect FEHBP if its consumer protections were greater or less than those practiced by the federal employee program. NARFE would prefer retaining the existing appeals process or enhancing it.

The Senate HELP Committee bill would require all individual and group market health insurance plans, including FEHBP, to offer dependent coverage for children up to age 26. Currently, most child dependents loose their FEHBP coverage by at the age of 22. The NARFE Legislative Program "supports legislation to provide that children of Federal civilian and military employees and retirees be permitted to remain under government-sponsored medical insurance plans until age 25 or the age generally allowed by larger medical insurers."

Employer Mandate

With the exception of small businesses, employers would be required by the House bill -- and the Senate Health, Education, Labor and Pensions (HELP) Committee bill -- to either provide their workers with health insurance or contribute to a fund that would help finance coverage for the uninsured through the "Health Insurance Exchange" system (described below). The effect of this requirement on the federal government should be minimal since nearly all federal employees, retirees and survivors are eligible to enroll in FEHBP. However, some temporary and seasonal federal workers are not currently eligible, and as a result, their agency may either be forced to insure them or pay into the Health Insurance Exchange Fund. The Senate Finance Committee proposal does not include an employer mandate.

Individual Mandate

All individuals would be required to have "acceptable health coverage" or pay a penalty, under the three major bills. Exceptions would be granted for dependents, religious objections and financial hardships. Federal workers or retirees who choose not to enroll in FEHBP, a spouse's employer-sponsored plan, Medicare, TRICARE, Veterans health care or some other form of coverage would pay a penalty.

Workers and retirees sometimes decline FEHBP enrollment because they cannot afford to pay their share of premiums. Beginning in 2014, the House legislation addresses this problem by allowing individuals who pay 10 percent or more of their income on employer-sponsored health premiums to enter the Health Insurance Exchange program. In addition, they would be eligible to obtain income-based "affordability credit" to help pay for premiums for plans offered by the exchange.

Health Insurance Exchange System

The House legislation would create "Health Insurance Exchanges" to provide private health insurance or coverage through a public option in which individuals and employers could purchase health benefits. In 2014 and thereafter, only those workers or retirees who spend 10 percent or more of their income on health plan premiums would be eligible to participate in the exchange program (described above in the "Individual Mandate" section). Starting in 2018, all workers and retirees could decline their employer-sponsored health plan and instead enter the exchange. The legislation does not require employers to pay for all or part of an exchange plan premium. However, persons with income at or below 400 percent of the federal poverty level ($73,240 for a family of three in 2009) would be eligible for an income-based sliding scale affordability credit which would pay part of the premium for a basic private or public health plan offered by the exchange.

The effect that such access would have on FEHBP would depend on how many federal workers and retirees eligible for the affordability credit leave FEHBP for the Health Exchange program.

The Senate Finance Committee appears to be embracing state nonprofit insurance cooperatives, based on a model used in Minnesota, owned and run by consumers, as an alternative to the health insurance exchanges proposed by the House or the related "American Health Benefit Gateways" in the Senate Health, Education, Labor and Pensions (HELP) Committee bill.

Taxing Health Benefits

The bipartisan group of members of the Senate Finance Committee, which continues to negotiate their version of the bill, has discussed taxing employees and retirees for part of the value of their employer-provided health insurance. Supporters of this proposal believe that excluding generous health plans provided by employers from personal income taxes insulates workers and retirees from the true cost of health care. In other words, in plans where enrollees pay little or nothing out-of-pocket, there is no incentive for enrollees to select plans, they would argue, that are more efficient and are better at containing costs, like Health Maintenance Organization options or

High Deductible Health Plans. In sum, supporters of ending or reducing the tax exemption of employer-sponsored health insurance hope to end the tax code's subsidization of so-called "gold-plated" coverage and make enrollees more cost-conscious of their health care choices. As a result, overall health care spending could be contained – a proposition supported by the Congressional Budget Office. What's more, there are few other ways to raise the amount of revenue necessary to pay for health care reform.

While highly-compensated executives and professionals in the private sector are sometimes provided such "Cadillac" coverage, many average "Ford" and "Chevy" level health plans can be just as expensive when they have a high proportion of workers and retirees which generate costly medical bills. In other words, premium amounts are not necessarily an accurate measure of a health plan's generosity, particularly when, as in the FEHBP, plans are experience-rated.

NARFE opposes taxing employees and retirees for part of the value of their employer-provided health plans.

There is one bit of good news for federal annuitants, however, if lawmakers opt to tax employees and retirees for their employer-sponsored health benefits. In discussions with the Senate Finance Committee, staff indicates that under options they have explored, federal annuitants would be less likely to be affected. That is because annuitants pay for their health insurance premiums with after-tax dollars, and therefore the amount they pay would not be counted as part of their income. However, federal annuitants would lose this advantage if premium conversion legislation, which would allow them to pay for their share of health insurance with pre-tax dollars, were to become law.

While none of the current health reform plans actually contains a provision taxing benefits -- and the possibility of such a proposal seems to be dimming -- final health reform policy, particularly in the Senate, has not been finalized. Indeed, as an alternative, there appears to be growing interest in taxing insurers or employers who offer insurance with premiums above a certain level. Insurers and employers would likely respond to such a tax by not providing coverage with premiums above the benchmark set in the legislation. For example, if the premium benchmark was $21,000 a year, then insurance carriers and employers would be less likely to offer plans with premiums above that amount since they would be obligated to pay a 35 percent surcharge tax on any plan with premiums above the cap level. That would force them to design benefits that would cost less than the benchmark. As a result, individuals could be prevented from buying more generous coverage.

More in-depth analysis of the taxation of health care insurance will appear in the September *NARFE* magazine.

<u>Long Term Effects of Reform</u>

The combination of the public plan option, taxation of health insurance and mandated benefit packages could affect the ability of employers and carriers to ensure competition and offer the same health plan choices in group health plans like the FEHBP.

However, concerns about the public plan may have been mollified by a deal struck between the moderate and conservative "Blue Dog" Democrats and Energy and Commerce Committee Chairman Henry Waxman. Instead of tying public plan payments to Medicare's rates of reimbursement to health care providers, as originally proposed, the compromise brokered in late July calls for the HHS Secretary to negotiate public plan rates with hospitals and doctors, just as private insurance companies do.

If carriers and the government, as an employer, can no longer offer plan competition and choice in FEHBP, the policymakers might question why the government is running a separate health care program for its employees and annuitants. As an alternative, they might suggest that federal workers and retirees be enrolled in the Health Insurance Exchange in lieu of FEHBP. For that to happen, however, the law authorizing the FEHBP would have to be amended, which the current health care reform legislation does not propose. NARFE would oppose legislation that would end FEHBP.

Currently, the House bill mandates studies in 2015 and 2019 to determine if there are significant groups (employer or employee) which would benefit from accessing the exchange. Such a study might consider that adding eight million enrollees from FEHBP, who have received comprehensive health care, could benefit the Health Insurance Exchange's "risk pool" and economy of scale because the health care needs of feds may have been better managed under FEHBP and, therefore, their cost to the exchange could be lower than other participants. Again, NARFE would oppose such a move.

Medicare and Medicaid

About half the cost of health care reform is paid for by reducing payments to providers in Medicare and Medicaid. Under the legislation, provider payments are not cut, but the rate at which they increase every year would be reduced. Although most doctors and hospitals are compelled to accept Medicare and Medicaid reimbursement because the programs control a huge share of all health care spending, NARFE is concerned that payment reform could encourage some medical providers to stop participating in Medicare and Medicaid. Other member groups of Leadership Council of Aging Organizations, a coalition of 53 national nonprofit organizations concerned with the well-being of America's older population, share NARFE's concerns.

Even when providers do not accept Medicare, the program, when combined with FEHBP coverage, will reimburse enrollees for physician and hospital costs. When providers don't accept Medicare, beneficiaries have to pay their bills up front, which can be unaffordable for many retirees and survivors who cannot wait for Medicare and their FEHBP plan to reimburse them.

NARFE supports a provision in the House bill which would end the "donut hole" in Medicare Part D prescription drug coverage, beginning with a $500 reduction in 2011, and completing the phase-out by 2023. In 2009, once Part D beneficiaries pay more than $2,700 in total annual drug costs, they are in the "donut hole" (a gap in coverage) and must pay 100 percent out-of-pocket for the cost of prescription drugs until their total out-of-pocket costs reach $4,350.

Under FEHBP coverage, federal annuitants simply pay co-payments and/or coinsurance for prescription drug coverage which is more generous than Part D. For that reason, the vast majority of retirees and survivors do not enroll in Medicare Part D.

The House and Senate bills would expand eligibility in Medicaid to cover millions of low-income people who do not qualify under current law and either do not have access to private insurance or cannot afford it. Medicaid is funded by the federal and state governments, which pay for medical and long-term care for low-income individuals and families. The House and Senate bills would make families or individuals eligible for Medicaid if they earn up to 133 to 150 percent of the federal poverty level, or between $29,300 and $33,075 in 2009. It is not clear if the bills would allow more childless adults to qualify for the program and whether long-term care benefits would be offered to newly eligible beneficiaries. Absent additional federal funding, cash-strapped states would be hard pressed to pay for the expansion.

Long-Term Care

The House bill and Senate HELP Committee legislation includes the "Community Living Assistance Services and Supports" (CLASS) Act which would establish a national insurance program to be financed by voluntary payroll deductions to provide benefits to adults who become severely functionally impaired. To qualify for benefits, individuals must be 18 years old and have contributed to the program at least 5 years.

While the CLASS Act would help Americans pay for long-term care, it has been criticized for providing a meager benefit of $50 to $75 a day, and it would depend on overburdened state government Disability Determination Services examiners to evaluate and process benefit claims.

NARFE supports financing a more generous long-term care benefit and establishing a more robust disability evaluation and benefit claims process than proposed in the CLASS Act.

The NARFE Legislative Program "supports proposals that would help individuals who cannot afford long-term care insurance or have an immediate or likely need for long-term care to receive such services without impoverishing themselves."

Consultation and Information Regarding End-Of-Life Planning

Much inaccurate and false information has been circulated about a provision in the House bill which would provide insurance coverage for consultation with medical practitioners about a patient's wishes with respect to life sustaining treatment. The provision covers what already has become commonplace when anyone of any age is admitted to a hospital and is asked to consider completing an "advance directive" form or a living will. None of the language in the bill mandates the rationing of end-of-life care to Medicare beneficiaries.

Stay Up-To-Date on Health Care Reform Legislation

The Legislation Department continues to closely examine any and all comprehensive health care proposals as the legislative process continues. NARFE Members will continue to be updated

through the *NARFE* Magazine, the Legislative Hotline and Action Requests. We encourage members with e-mail access to join the Rapid Response team. By e-mailing memsrvcs@narfe.org and joining the program, members receive our weekly Legislative Hotline (when Congress is in session), but more importantly, any urgent action requests. Legislation changes quickly on Capitol Hill so NARFE's ability to quickly engage our grassroots is a powerful tool to protect earned benefits.

If you have further questions regarding comprehensive health care reform or the process, please contact the Legislation Department at 703-838-7760 or leg@narfe.org.